STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING _____ B. WING _____	03/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY VILLAGE NURSING HOME	3518 S SHELBY ST INDIANAPOLIS, IN46227

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F0000	This visit was for a Recertification and State Licensure survey. Survey Dates: March 13, 14, 15, 16, & 17, 2011 Facility Number: 000142 Provider Number: 155237 AIM Number: 100266940 Survey Team: Rhonda Stout RN TC (March 13, 14, & 17 2011) Marcy Smith RN Leia Ally RN (March 13, 15, 16, & 17 2011) Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 6 Medicaid: 52 Other: 13 Total: 71 Sample: 15 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3-22-11 Cathy Emswiller RN	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review or Post Certification Review on or after 04/16/2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0157 SS=D	Based on record review and interview the facility failed to notify the physician in a timely manner regarding a diastolic blood pressure outside of ordered call parameters for 1 of 13 residents reviewed for physician notification in a sample of 15. (Resident #56) Findings included: The record of Resident #56 was reviewed on 1/14/11 at 9:00 am. Diagnoses for Resident #56 included, but were not limited to, high blood pressure and history of a stroke with left side affected. A recapitulated physician's order for March, 2011, with an original date of 12/29/04, indicated the resident was to have her blood pressure and heart rate checked weekly and the physician was to be called if her diastolic blood pressure (DBP) was over 90. DBP is the minimal blood pressure when the heart is at rest. The Medication Administration Record (MAR) for January, 2011, indicated on 1/19/11 Resident #56's DBP was 100. There was no documentation to indicate the physician had been notified. Further information about physician notification	F0157	F157 483.10(b)(11) Notify of changes (injury/decline/room, etc.) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #56 had physician notified of DBP of 100 on 3/14/11 at 5:30PM with no changes in orders. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A chart audit identified	04/16/2011

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	of the DBP of 100 was requested from the Director of Nursing (DON) on 3/14/11 at 5:30 PM. \During an interview on 3/15/11 at 9:00 am the DON indicated the physician had not been notified at the time of the occurrence. She provided a typed memo indicating "MD was notified 03/14/2011 of [Resident #56's] diastolic of 100. No order changes." 3.1-5(a)(2)		residents who require blood pressure monitoring. · Residents have blood pressures outside established parameters reported to the physician. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Director of Nursing Services reviewed the policy on *Change of Condition* for physician notification. · Nursing staff was inserviced on or before 4/12/2011 by the Director of Nursing Services (DNS) regarding physician notification of abnormal blood pressures. · Blood pressure parameters are listed on the Medication Administration Record (MAR). · Nurses notify physician of blood pressures outside established parameters via fax or phone based on physician preference. · Abnormal blood pressure and effort to notify physician is placed on the 24 Hour Condition Report. · The 24 Hour Condition	

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			Report is reviewed by the Interdisciplinary Team (IDT) in morning meeting for any clinical concerns. · Nurse managers review charts with identified concerns for physician notification. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Qualified Designee is responsible for the completion of the *Change of Condition* audit tool for physician notification of abnormal blood pressures for one unit per day for four weeks, monthly for two months, then quarterly thereafter with results reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If threshold is not achieved an action plan may be developed to ensure compliance.	

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F0282 SS=D	Based on record review and interview the facility failed to ensure physician and nursing plans of care were followed for reporting blood pressures outside call parameters, taking weekly blood pressures and heart rates and monitoring the heart rate of a resident with a pacemaker for 2 of 13 residents reviewed for their plans of care being followed in a sample of 15. (Residents #56 and #69) Findings included: 1. The record of Resident #56 was reviewed on 1/14/11 at 9:00 am. Diagnoses for Resident #56 included, but were not limited to, high blood pressure and history of a stroke with left side affected. A recapitulated physician's order for March, 2011, with an original date of 12/29/04, indicated the resident was to have her blood pressure and heart rate checked weekly and the physician was to be called if her diastolic blood pressure (DBP) was over 90. DBP is the minimal blood pressure when the heart is at rest. The Medication Administration Record (MAR) for January, 2011, indicated on 1/19/11 Resident #56's DBP was 100.	F0282	F282 483.20k(3)(ii) Services by qualified persons/per care plan The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #56 has blood pressure and heart rate checked based on the written plan of care. · Resident #69's cardiologist was contacted with weekly frequency established for heart rate check. Resident #69's heart rate is checked based on the written plan of care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · A chart audit identified residents who require blood pressure monitoring, heart rate monitoring and have pacemakers. · Residents requiring blood pressure and heart rate monitoring and who have pacemakers, have blood pressure and heart rate monitored based on the written plan of care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Director of Nursing	04/16/2011

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	There was no documentation to indicate the physician had been notified. Further information about physician notification of the DBP of 100 was requested from the Director of Nursing (DON) on 3/14/11 at 5:30 PM. During an interview on 3/15/11 at 9:00 am the DON indicated the physician had not been notified at the time of the occurrence. She provided a typed memo indicating "MD was notified 03/14/2011 of [Resident #56's] diastolic of 100. No order changes." The MAR for February, 2011, indicated the resident was to have her blood pressure and heart rate checked on 2/2, 2/9, 2/16, and 2/23, 2011. The record did not indicate these assessments were done on 2/2/11. Further information was requested from the DON on 3/14/11 at 5:30 PM regarding the missing blood pressure and heart rate. No further information was provided by the final exit on 3/17/11 at 5:00 PM. 2. The record of Resident #69 was reviewed on 3/17/11 at 10:30 AM. Diagnoses for Resident #69 included, but were not limited to, atrial fibrillation, stroke and placement of a cardiac		Services (DNS)developed a procedure for *Monitoring Blood Pressure and Heart Rate*. · Nursing staff was inserviced on or before 4/12/2011 by the DNS regarding monitoring blood pressures and heart rates. · Blood pressures and heart rates are documented in the medical record. · The Medication Administration Record (MAR) is reviewed for routine blood pressures and heart rates by nurse managers no less than monthly with month-end recapitulation review. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/Qualified Designee is responsible for the completion of the *Monitoring Blood Pressure and Heart Rate* audit tool for monitoring of blood pressures and heart rates for one unit per day for four weeks, monthly for two months, then quarterly thereafter with results reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If threshold is not achieved an action plan may be developed to ensure compliance.	

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	pacemaker in April, 2006. A care plan for Resident #69 dated 1/1/11, current through 6/6/11, indicated a problem of "Resident has risk for pacemaker failure related to pacemaker placement for sick sinus syndrome." The goal was "Resident will not experience signs of pacemaker failure as evidenced by: pulse less than 60..." Approaches included...Observe for signs of pacemaker failure (pulse of [less than] 60..." The MARs and nurses notes for January and February, 2011 indicated the residents pulse had been checked on 1/10/11, 2/16/11, 2/28/11 and 2/29/11. No other pulses were documented. Further information was requested from the DON on 3/17/11 at 12:45 PM regarding the lack of heart rate assessments for the resident. During an interview on 3/17/11 at 3:55 PM she indicated the resident's pulse had not been checked on a regular basis. She indicated "It should have been and will be, starting tomorrow." 3.1-35(g)(2)			

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F0329 SS=E	Based on record review and interview the facility failed to ensure residents did not receive anti-anxiety or pain medications without first attempting non pharmaceutical interventions. This affected 4 out of 15 residents reviewed for unnecessary medications in a sample of 15. (Residents #36, #60, #40, and #59) Findings include: A review of facility policy, provided by the Director of Nursing, on 3/16/2011 at 10:30 a.m. entitled," Psychoactive/Behavior Management Program," and deemed current, included, "Prior to the administration of medication, nursing interventions will be attempted and documented." A review of the facility policy, provided by the Director of Nursing, on 3/17/2011 at 4:20 p.m. entitled, "Pain Management," and deemed current, included, "A plan of care...individualized to the resident, addressing potential side effects, limitations due to pain, behavioral symptoms, and alternative pain relief techniques." 1. The record for Resident #36 was reviewed on 3/14/2011 at 3:00 p.m.	F0329	F329 483.25(l) Drug Regimen is Free from Unnecessary Drugs Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences, which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #36 has non-medication interventions offered and documented prior to administration of anti-anxiety or pain medication. · Resident #60 has non-medication interventions offered and documented prior to administration of pain medication. · Resident #40 has non-medication interventions offered and documented prior to administration of pain medication. · Resident #59 has non-medication interventions offered and documented prior to administration of anti-anxiety. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	04/16/2011

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	Diagnoses for Resident #36 included, but were not limited to uterine papillary serous cancer, osteoporosis, osteoarthritis, anxiety, depression, and hypertension. A care plan related to pain with a problem start date of 3/1/2011 and goal target date 6/1/2011, indicated for the resident to receive, "Non medication interventions such as rest, quiet environment, therapies as ordered." A care plan related to anxiety with a problem start date of 1/27/2011 and a goal target date of 6/1/2011, indicated for the resident to be, "encourage to attend activities, to eat meals in the main dining room, and will be provided with supportive reassurance and listening." A recapitulated doctor's order with an original date of 8/2/2010, indicated the resident was to receive, Lorazepam 0.5 milligrams, take 1 tablet by mouth every 8 hours as needed for anxiety. A recapitulated doctor's order with an original date of 8/2/2010, indicated the resident was to receive, Norco 5-325 milligram tablet, 1 tablet by mouth every 4 hours as needed for mild to moderate pain.		**corrective action will be taken?** · A chart audit identified residents who require as needed (PRN) anti-anxiety and pain medication. · Residents with PRN anti-anxiety and pain medication have non-medication interventions offered and documented prior to administration of PRN anti-anxiety or pain medication. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Director of Nursing services reviewed the policies on *Pain Management Program and Medication Administration*. · Nursing staff was inserviced on or before 4/12/2011 by the Director of Nursing Services (DNS) offering and documenting non-medication interventions prior to administering PRN anti-anxiety and pain medications. · Non-medication interventions are documented in the medical record prior to administration. · PRN anti-anxiety and pain medications usage is reviewed no less than quarterly by nurse managers for necessity and appropriateness of continued use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/Qualified Designee is	

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	A recapitulated doctor's order with an original date of 8/2/2010, indicated the resident was to receive, Norco 5-325 milligram tablet, 2 tablets by mouth every 4 hours as needed for moderated to severe pain. The March 2011 medication administration record indicated the resident receive the following medications without offering non medication interventions prior to the administration of the medications Lorazepam and or Norco: Lorazepam 0.5 milligrams was given on the 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 16. A Norco 5-325 milligram tablet on 6 and 14. Two Norco 5-325 tablets on the 15. The February 2011 medication administration record indicated the resident received the following medications without offering non medication interventions prior to the administration of the medications Lorazepam and or Norco: Lorazepam 0.5 milligrams was given on the 2, 3, 4, 5, 7, 8, 9, 10, 11, 12,13,14,15,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27. Norco 5-325 milligram tablet was given on 2 and 25. Two Norco 5-325 milligram tablets were given on 5 and 6.		responsible for the completion of the *Unnecessary Medication* audit tool for non-medication interventions for one unit per day for four weeks, monthly for two months, then quarterly thereafter with results reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If threshold is not achieved an action plan may be developed to ensure compliance.	

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	The January 2011 medication administration record indicated the resident received the following medications without offering non-medication interventions prior to the administration of the medications Lorazepam and or Norco. Lorazepam 0.5 milligrams was given on the 2, 3, 4, 5, 10, 11, 12, 13, 14, 17, 18, 21, 22, 23, 24, 29, and 30. Two Norco 5-325 milligram tablets were given on 1, 6, 7, 8, 9, 14, 22, and 23. 2. The record for Resident #60 was reviewed on 3/17/2011 at 10:45 a.m. Diagnoses included, but was not limited to end stage renal disease with dialysis, hypertension, cerebrovascular accident (stroke) with hemiparesis, diabetes mellitus, and gastroesophageal reflux disease. A care plan related to pain with an original date of 2/23/2011 and a goal target date of 5/23/2011, indicated the resident was to have, "Non medication interventions such as rest, quiet environment, therapies as ordered." A recapitulated doctor's order with an original date of 8/19/2011, indicated the resident was to receive two Norco 5-325			

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	milligram tablets by mouth every 4 hours as needed for pain. The March 2011 medication administration record indicated the resident received two Norco 5-325 milligram tablets without offering non medication interventions prior to the administration of the medication Norco: March 1, 2, 3, 4, 6, 7, and 11. The February 2011 medication administration record indicated the resident received two Norco 5-325 milligram tablets without offering non medication interventions prior to the administration of the medication Norco: February 1,2,3, 4, 8, 9, 11, 12, 13, 14, 15, 17, 18, 21, 23, 24, 25, 26, 27, and 28. The January 2011 medication administration record indicated the resident received two Norco 5-325 milligram tablets without offering non medication interventions prior to the administration of the medication Norco: January 2, 3, 4, 5, 6, 18, 20, 21, 22, 24, 25, 27, 29, 30, and 31. 3. The record for Resident #40 was reviewed on 3/14/2011 at 9:30 a.m. A care plan related to pain with an			

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	original date of 2/11/2011 and a target date of 5/11/2011, indicated the staff was to, "Offer non pharmacological interventions such as quiet environment, rest, shower, back rub, and reposition," prior to medication administration. A recapitulated doctor's order with an original date of 2/1/2011, indicated to give the resident morphine sulfate 20 milligrams/milliliter, 0.5 milliliter every 2 hours as needed for Dyspnea or severe pain. A recapitulated doctor's order with an original date of 9/10/2010, indicated to give the resident Vicodin 5-500, one tablet every 4 hours as needed for pain. The March 2011 medication administration record indicated the resident receive the morphine sulfate on the 1st without providing non medication interventions prior to the medication morphine sulfate. The February 2011 medication administration record indicated the resident received Vicodin 5-500 on the 19, for pain, without offering non medications interventions prior to the medication Vicodin.			

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	The January 2011 medication administration record indicated the resident received Vicodin 5-500 on the 1, 4, and 6, for pain, without offering non medication interventions prior to the medication Vicodin. On 3/14/2011, a request from the Director of Nursing to provide further information in regards to other interventions offered to the resident prior to the medication administration. As of exit on 3/18/2011, no further information was provided.			

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	155237	A. BUILDING _____ B. WING _____	03/17/2011

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F0329 SS=E	4. The record of Resident #59 was reviewed on 3/13/11 at 1:00 PM. Diagnoses for Resident #59 included, but were not limited to, dementia with agitation and depression. A care plan for the resident, with an original date of 1/19/11 and current through 4/19/11 indicated a problem of "At risk for side effects related to receiving psychotropic medications." Approaches to preventing the side effects included "...Attempt non-pharmacological interventions." A recapitulated physician's order for March, 2011, with an original date of 7/12/10, indicated Resident #59 could receive Lorazepam (an anti-anxiety medication) 0.5 milligrams every 12 hours as needed for anxiety. The Medication Administration Records (MARs) for December, 2010, January, 2011 and February, 2011, indicated she received Lorazepam on 12/9/10 and 12/16/10, 1/27/11 and 2/27/11. There was no indication on the MARs or in the nurses' notes any non-pharmacological interventions had been tried prior to giving the resident the anti-anxiety	F0329	F329 483.25(l) Drug Regimen is Free from Unnecessary Drugs Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences, which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #36 has non-medication interventions offered and documented prior to administration of anti-anxiety or pain medication. · Resident #60 has non-medication interventions offered and documented prior to administration of pain medication. · Resident #40 has non-medication interventions offered and documented prior to administration of pain medication. · Resident #59 has non-medication interventions offered and documented prior to administration of anti-anxiety. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	04/16/2011

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	medication. Further information regarding the use of any non-pharmacological interventions for Resident #59's anxiety was requested from the Director of Nursing (DON) on 3/13/11 at 3:30 PM. No further information was provided by final exit on 3/17/11 at 5:00 3.1-48(a) 3.1-48(b)(1)		**corrective action will be taken?** · A chart audit identified residents who require as needed (PRN) anti-anxiety and pain medication. · Residents with PRN anti-anxiety and pain medication have non-medication interventions offered and documented prior to administration of PRN anti-anxiety or pain medication. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Director of Nursing services reviewed the policies on *Pain Management Program and Medication Administration*. · Nursing staff was inserviced on or before 4/12/2011 by the Director of Nursing Services (DNS) offering and documenting non-medication interventions prior to administering PRN anti-anxiety and pain medications. · Non-medication interventions are documented in the medical record prior to administration. · PRN anti-anxiety and pain medications usage is reviewed no less than quarterly by nurse managers for necessity and appropriateness of continued use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/Qualified Designee is	

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			responsible for the completion of the *Unnecessary Medication* audit tool for non-medication interventions for one unit per day for four weeks, monthly for two months, then quarterly thereafter with results reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If threshold is not achieved an action plan may be developed to ensure compliance.	